

MEDI-CAL SUPPLEMENTAL COST REPORT

INSTRUCTIONS

MEDI-CAL SUPPLEMENTAL COST REPORT INSTRUCTIONS

These instructions are prepared to assist the provider in completing the Medicare cost report form (CMS 2552-96) and Medi-Cal Supplemental Cost Report Schedules in conformity with state Medi-Cal cost reporting requirements. These modification procedures must be used by all providers filing cost reports for fiscal periods beginning on or after July 1, 1997. Except where otherwise instructed by these instructions, providers are to follow the procedures outlined in CMS Publication 15-2, Chapter 36.

Filing of this cost report must be in compliance with the state Medi-Cal cost reporting requirements and/or current Financial Audits Branch policies. Any or all costs claimed for reimbursement under these reporting requirements are subject to reimbursement requirements per Title 42, Code of Federal Regulations (CFR) and the state Medi-Cal plan.

All providers must file the following completed documents:

1. Two sets of form CMS 2552-96
2. One set of financial statements
3. One set of the working-trial balance
4. Two sets of Medi-Cal Supplemental Cost Report Schedules [DHS 3092 (12/05)]
5. Three sets of the Rate Development Branch schedules [DHS 3094 (08/05)], unless you are exempt

The documents must be complete and legible. Reduced copies will not be accepted. If your cost report is prepared using one of the approved computer processing system formats, the printouts must be on pages which can be separated without destroying any of the data. The completed cost report, financial statements, and supplemental work sheets are to be submitted to:

U.S. Mail

California Department of Health Services
Audits and Investigations
Audit Review and Analysis Section
1500 Capitol Avenue, MS 2109
P.O. Box 997413
Sacramento, CA 95899-7413

Fed Ex, UPS

California Department of Health Services
Audits and Investigations
Audit Review and Analysis Section
1500 Capitol Avenue, MS 2109
Sacramento, CA 95814

If your cost report reflects a settlement due the State, remittance must be made payable to the Department of Health Services. Forward remittance to:

California Department of Health Services
Recovery Section – Overpayment Unit
MS 4720
P.O. Box 997421
Sacramento, CA 95899-7421

To ensure that payments are credited to the proper fiscal period, please identify the fiscal year and/or settlement letter number that applies to any remittance. It is recommended that a separate remittance be made for each different program settlement [i.e., Contract, Noncontract, Rural Health Clinic, County Medical Services Program (CMSP)]. A **copy** of the check remittance should be included with the cost report package.

Inquiries concerning cost report submission should be directed to the California Department of Health Services (DHS), Audits and Investigations (A&I), Audit Review and Analysis Section, at (916) 650-6696. Questions regarding contract hospital matters should be directed to the Department's Hospital Contract Unit at (916) 552-8015. Questions regarding the CMSP Program should be directed to the CMSP Governing Board Office at (916) 649-2631.

CONSOLIDATED FACILITY LICENSING AND COST REPORT FILING

Providers should be aware that this policy does not supersede the Department's authority pursuant to Section 14170 of the Welfare and Institutions Code to require the hospital to file separate cost reports for each facility.

If your licensure consolidation falls into the cost report filing period, Health and Safety Code, Section 1250.8, permits a general acute care hospital, upon approval by the Department, to receive a single consolidated license to operate as one acute care hospital although facilities are located at more than one location. If a general acute care hospital chooses to consolidate operations, this new entity, pursuant to Welfare and Institutions Code, Section 14170, at its option, may use a single provider number for all the consolidated facilities or may continue to use separate provider numbers for each facility location.

Providers who have received a consolidated licensure for acute inpatient services from the Department's Licensing and Certification since January 1, 1996, will be required to complete a Cost Report Filing Questionnaire. This form will serve as the provider's election on cost report filing and provide pertinent information related to hospital operating changes as a direct result of the consolidation. Once an election to file either separate cost reports or a consolidated cost report is established, any subsequent change will require prior approval from Audits and Investigations. The Cost Report Filing Questionnaire will be sent to those providers that have been identified as having received a consolidated license.

HOME OFFICE

Home office costs represent the overhead functions that the chain providers have chosen to perform at a central location. Chain providers consist of related organizations through either common ownership or common control.

CMS Publication 15-1, Sections 2150 through 2153 states that organizations that own or manage two or more facilities participating in the program must file annual detailed home office cost reports. The California Department of Health Services must be furnished with a detailed Home Office Cost Report as a basis for reimbursing the facility for home office costs.

If the structure of your organization falls under the above definition as a home office:

- File two copies of the Medi-Cal Home Office cost report (DHS HO) within 150 days from the end of your fiscal period to the California Department of Health Services.

Note: Copies of the Medicare home office cost report in lieu of the Medi-Cal cost report are acceptable.

- Submit home office financial statements and/or a trial balance of the general ledger with the home office cost report.

FREESTANDING PSYCHIATRIC HOSPITALS AND ACUTE CARE HOSPITALS WITH PSYCHIATRIC SERVICES

Chapter 633, Statutes of 1994, Assembly Bill 757, provided for consolidation of authorization of fee-for-service/Medi-Cal and Short-Doyle/Medi-Cal psychiatric inpatient hospital services at the county level, effective January 1, 1995. Under this program, the California Department of Health Services transferred responsibility for the authorization of Treatment Authorization Requests (TARs) for psychiatric inpatient hospital services to the county's Mental Health Plan (MHP).

Providers are to bill psychiatric inpatient hospital services using the mental health provider number (**HSM** prefix).

- Psychiatric and rehabilitation costs should be treated as a part of adults and pediatric cost unless they meet the requirements of a special level of care. If the psychiatric and rehabilitation unit qualifies as a special level of care in a hospital by meeting the requirements according to CMS Publication 15-1, Sections 2202.7 and 2336–2336.3, report the psychiatric data on CMS 2552 as a subprovider and not under the "Hospital" category.
- Report psychiatric data on the Medi-Cal Supplemental Cost Report [DHS 3092 (12/05)] Schedule 8.
- Do not report psychiatric data on the Rate Development Branch schedules (DHS 3094).

Medi-Cal reimbursement for psychiatric inpatient hospital services will be based on per diem rates and will not be subject to cost settlement.

Psychiatric-only hospitals must continue to file cost reports with the California Department of Health Services.

Psychiatric-only hospitals do not need to complete Rate Development Branch schedules [DHS 3094].

RURAL HEALTH CLINIC (RHC)/FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES

If you operate a hospital-based RHC or FQHC facility, you must complete Cost Report Worksheets M-1 through M-5 for each clinic in accordance with form CMS 2552-96 instructions.

The Department's review of previously filed form CMS 2552-96 cost report revealed that many hospital-based providers did not complete the required worksheets to properly identify RHC or FQHC reimbursable cost. Beginning with fiscal years ending 2005, all providers having a hospital based RHC or FQHC must submit CMS 2552-96 in the following manner:

- Worksheet S-2 – The Hospital and Hospital-Based Component Identification section requires RHCs and FQHCs to be listed on lines 14 through 14.09 and FQHCs to be listed on lines 14.10 through 14.19, and identify their facility and issued provider number. Separate statistical records for each clinic(s) must be maintained for proper determination of reimbursable costs. If you have more than one of these clinics, complete a separate worksheet (Worksheet M1-M5) for each facility.
- Worksheet A – Line 63 is used to report the costs of provider-based RHCs and FQHCs. If more than one is maintained and/or other services are reported on this line, subscript the line. When reporting RHCs and FQHCs on these lines, subscript the line beginning with lines 63.50 through 63.59 and 63.85 through 63.99 for RHC and 63.60 through 63.84 for FQHC.
- Worksheet M Series – CMS requires RHC/FQHC that render services on and after January 1, 1998 to complete Worksheet M-1 to M-5, in accordance with Title 42, Code of Federal Regulations (CFR) Sections 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c). Worksheet M-1 to M-5 must be completed for each clinic.

In addition, you must complete the Medi-Cal Supplemental Cost Report Schedule 9 "Summary of Medi-Cal Charges for RHC/FQHC" and Schedule 10 "Summary of Medi-Cal RHC/FQHC Settlement" for each clinic.

MEDI-CAL SERVICES PROVIDED UNDER MANAGED CARE CONTRACTS

- Do not report the Medi-Cal managed care charges referenced on these schedules as Medi-Cal charges on CMS 2552-96; however, they are a component of the total charges reported on Work Sheet C. Likewise, the Medi-Cal managed care inpatient days for the various levels of care should not be reported in the Medicare cost report Worksheets D-1 and S-3; but they are included in reported total days on these work sheets.

DISTINCT PART NURSING FACILITY (DPNF) AND SUBACUTE ANCILLARY COSTS INCLUDED IN THE MEDI-CAL PER DIEM RATES

Background

Certain ancillary services defined in Title 22 are included in DPNF and subacute Medi-Cal per diem rates. Accordingly, the costs associated with these services are includable in the Medi-Cal per diem rates. Further, the costs associated with these services must be correctly reported on the DPNF and Subacute cost center lines on the Medicare cost report form (CMS 2552-96). Therefore, the purpose of the following instructions is to promote the accurate reporting of ancillary costs applicable to DPNF and subacute facilities on the Medicare cost report form.

Cost Report Instructions

DPNF providers shall report ancillary service costs included in the DPNF rate pursuant to Title 22, CCR Section 51511, on the appropriate DPNF cost report line provided on the Medicare cost report form (CMS 2552-96).

Subacute providers shall report ancillary service costs included in the subacute rate, as stated in Title 22, CCR, Section 51511.5, and the provider's contract with the Department, on the appropriate subacute cost report line provided on the Medicare cost report form (CMS 2552-96).

Pediatric subacute providers shall report ancillary service costs included in the pediatric subacute rate, as stated in Title 22, CCR, Section 51511.6, and the providers contract with the Department, on the appropriate subacute cost report line provided on the Medicare cost report form (CMS 2552-96).

MEDI-CAL CREDIT BALANCES

The Financial Audits Branch (FAB) of Audits and Investigations (A&I) performs a review of credit balances at the time of the cost report audit. This review is not limited to the cost report period but extends up to the date of the fieldwork performed by the auditor. This review includes a test of the receivable for accounts that have credit balances, and a review of the EDS Paid Claims Summary Reports for possible duplicate payments or overpayments.

The Centers for Medicare and Medicaid Services (CMS) requires that providers complete an annual report of credit balances as a part of the hospital cost report and this requirement applies to Medi-Cal Credit Balances. This report should cover the cost report period and should include all activities up to the date of the preparation of the Credit Balance Report. Please note it is the provider's responsibility to maintain an effective system to prevent, detect in timely fashion, and take proper corrective action for Medi-Cal overpayments.

- Report any outstanding Medi-Cal Credit Balances on the Medi-Cal Supplemental Cost Report (DHS 3092) Schedule 11 when the balance has been outstanding for 90 days or more from the preparation date of the credit balance report. The preparation date is the date you began to prepare the Medi-Cal cost report.
- Prepare one Medi-Cal credit balance report for each provider number that has an outstanding credit balance. Example: If you are reporting credit balances for long-term care, acute hospital inpatient services, acute hospital outpatient services, and CMSP services, four separate reports should be prepared.
- Amounts identified on Claims Inquiry Forms (CIFs) in process that are outstanding for less than one year should be removed from the Medi-Cal Amount Outstanding column.
- Amounts identified on Claims inquiry forms in process that are outstanding for more than one year should be included in the Medi-Cal Credit Balance Outstanding column.
- The reported outstanding Medi-Cal credit balances will be examined at the time of the audit for final settlement instead of at the time of cost report submission. Collection will be done in conjunction with the cost report audit.
- Do *not* carry forward the outstanding credit balance amount through to the cost report.

Note: You are required to retain and make available upon request by the A&I audit staff the accounts receivable aging report and credit balance report used to prepare the Medi-Cal credit balance report.

MODIFICATION OF CMS 2552-96

These instructions will be used in modifying the Medicare cost report form CMS 2552-96, during the fiscal period in which both cost reimbursement and contract per diem payments were in effect. Cost reimbursement refers to payments on services excluded from contract services during the precontract period and noncontract services billed under the provider's fee-for-service provider number.

Providers who have both contract and noncontract services during the fiscal period must submit two sets of data for Medi-Cal; one for the contract services, the other for cost reimbursed services. The exceptions are Worksheets A, B, B-1, and C where only one set is necessary. **Contract Services must be reported on Title V and noncontract (cost settlement) services must be reported on Title XIX.**

On the specific worksheet of the Medicare cost report form CMS 2552-96. The following modification instructions must be used for the Medicare cost report (CMS 2552-96) worksheets identified:

Worksheet S, Part I

Complete this worksheet. If a contract hospital, enter the contract provider number.

Worksheet S, Part II

Separately identify each RHC/FQHC and complete DHS 3092, Schedules 9 and 10.

Worksheet S-2

Complete this worksheet. For the contract period, separately identify contract provider number, date of contract, and cost report period.

Worksheet S-3

Hospitals that have a DPNF must enter information on the NF line. A DPNF is a separately licensed skilled nursing level of care provided in an acute care hospital. It has a separate provider number and rates of payment are prospective and final.

Hospitals that provide psychiatric services either as a freestanding psychiatric hospital or as an acute care hospital with psychiatric services must enter the data under Subprovider Medi-Cal Psychiatric Inpatient Hospital Services on Worksheet S-3, Part 1.

Complete the discharge data in accordance with California Code of Regulations (CCR) Title 22, Division 3, Section 51536. Cost reports submitted without the discharge data will be returned as incomplete.

Identify the discharge information to the contract and noncontract periods.

Worksheet A

Psychiatric inpatient care units which meet all the criteria of CMS Publication 15-1, Section 2336, and are licensed as a subprovider, must file subprovider data and report the data on lines 30–31. Otherwise, the provider should combine the psychiatric service with Adults and Pediatric after the cost allocation on Worksheet B, Part I, column 27.

Worksheet A-8-2

Enter in column 4, the total professional component for patient care services rendered.

Worksheet D-1, Parts I and II

Complete these worksheets when applicable for Title XIX cost apportionment; ensure that contract and cost reimbursable items are reported separately. Contract services data are to be reported on Title V and noncontract (cost settlement) services data on Title XIX

Unless provider meets the criteria of CMS Publication 15-1, Section 2336, total psychiatric services data should be combined with adults and pediatrics data. If the two centers are not combined on Worksheet A, they must be combined after the cost allocation on Worksheet B, Part I, column 27.

Report Medi-Cal psychiatric days on DHS 3092, Schedule 8 only.

Do not include the Medi-Cal administrative days. See Worksheet E-3, Part III, line 4, instructions.

Transfer the total program inpatient cost from line 49 to Worksheet E-3, Part III, line 1.

Worksheet D-4

Complete this worksheet when applicable. Transfer line 101, column 3, to Worksheet D-1, Part II, line 48.

Worksheet E-3. Part III

Enter on line 4, Administrative Days Costs—In accordance with CCR, Title 22, Division 3, Sections 51536 and 51542, Administrative Days are reimbursed on prospective and final rates based on the facility's specific DPNF rate or the median rate. Delete the existing line description "Organs Acquisition" and write "Administrative Day Cost." Enter the reimbursable cost computed from DHS 3092, Schedule 7.

Enter on lines 33 and 36, Medi-Cal Patient Liability and Other Coverage (PL and OC). PL and OC should not be combined with the interim payments reported on Worksheet E-3 Part III, line 57.

The reported amount for interim payments on line 57 must reflect the sum of all interim payments on individual bills plus those that are still considered receivable for which payment can be expected.

Appeal Items: In accordance with CMS Publication 15-2, Chapter I, Section 115.2B, if a provider continues to claim certain cost items determined unallowable in a prior audit, it will be considered a fraudulent or abusive claiming practice. If the provider wishes to preserve appeal rights on the cost report of such items, the amount may be entered on line 59. This amount must agree with DHS 3092, Schedule 7.

Financial Statement

The hospital's balance sheet and income statement are required to be submitted with the cost report. If financial statements are not available at the time the cost report is to be submitted, a trial balance of the hospital's general ledger will be accepted. Regardless of whether financial statements or a trial balance is submitted, the hospital must include schedules that reconcile expenses to Worksheet A, ancillary revenue to Worksheet C, and total revenue to Worksheet G-2.

**MEDI-CAL COST REPORT SCHEDULES
(DHS 3092 SCHEDULES)**

Completion of the Medi-Cal supplemental cost report schedules does not exempt the provider from filing the Medicare cost report form (CMS 2552-96) as mentioned above.

MEDI-CAL SUPPLEMENTAL COST REPORT SCHEDULES DESCRIPTION (DHS 3092)**Schedule 6, Summary of Medi-Cal Charges**

All providers must complete these pages.

Schedule 7, Summary of Medi-Cal Settlement

For all providers, disclose each appeal issue and its Medi-Cal net effect. Transfer the total amount to CMS 2552-96, Worksheet E-3, Part III, line 59.

Schedule 8, Summary of Medi-Cal Psychiatric Inpatient Hospital Services

Complete this page if you performed psychiatric inpatient hospital services for Medi-Cal patients during the reporting period.

Schedule 9, Summary of Medi-Cal Charges and Ancillary Costs for RHC/FQHC; and Schedule 10, Summary of Medi-Cal RHC/FQHC Settlement

Complete Schedules 9 and 10 for each RHC/FQHC provider during the reporting period. The Core RHC/FQHC services are transferred from CMS 2552-96, Worksheet M-3. The related ancillary service costs are determined on Schedule 9.

Schedule 11, Medi-Cal Credit Balance Report for Inpatients and Outpatients

Complete this page. Duplicate if needed.